In contrast, outlays for Medicaid increased at an annual rate of only 11.6 percent during the period. While Medicaid faced the same rapid increases in the cost of medical care that Medicare did, other factors worked to reduce outlays, especially in 1982.

Federal budget cuts were perhaps the most important reason for slower Medicaid growth. Medicaid program changes made as part of the 1981 Reconciliation Act caused outlays to be 5 percent lower in 1982 than they would otherwise have been. The major cut was a 3 percent reduction in federal grants in 1982 from the amount otherwise payable (4 percent in 1983 and 4.5 percent in 1984), with provision for partial restoration in states meeting certain criteria. 4/ In addition, states were allowed substantially more discretion in the areas of hospital reimbursement and coverage of persons who qualify for Medicaid only when medical bills are subtracted from income (the medically needy). Changes in Aid to Families with Dependent Children (AFDC) in the 1981 act also reduced Medicaid outlays by reducing the number of persons automatically eligible for Medicaid.

In addition, state budget crises played a role in slowing growth in Medicaid. States have significant discretion in the areas of eligibility, benefits, and reimbursement, and numerous cuts were made in these areas at state initiative.

The Current Situation

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) made additional cuts in Medicare and Medicaid, though in contrast to the previous year's law the new cuts were concentrated on Medicare. Medicare cuts will save $11.3 billion over the 1983-1985 period--or 5.4 percent of what outlays would have been. Since only $1.5 billion of the savings will be realized in 1983, however, outlays are estimated to increase 14.7 percent over 1982. 5/ Medicaid cuts were much smaller, totaling $1.0 billion--or 1.5 percent--over the three-year period.

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4. The criteria are high unemployment, effective hospital cost control programs, documented fraud and abuse reductions, or very low rates of increase in Medicaid spending.

5. These figures exclude accounting savings from a temporary delay in Medicare's interim payments to some hospitals. In addition, they exclude the impact of the increase in SMI premiums, which changes the financing of that program but does not diminish program spending.

Most of the Medicare reductions were in reimbursements to hospitals. A major step was taken toward changing the reimbursement system from a retrospective cost-based one to a prospective one. 6/ Targets for rates of growth in costs per admission from 1982 levels were established for 1983, 1984, and 1985, with bonuses to be paid to hospitals below their targets and penalties for hospitals above their targets. In addition, limits on routine costs were replaced by limits on total operating costs per admission. Outlay reductions from this and other hospital reimbursement changes will amount to $8.5 billion over the 1983-1985 period.

Some of the other program changes in Medicare included in TEFRA also reflect significant changes in policy. Medicare benefits were made secondary to employment-based private insurance for employed beneficiaries aged 65-69. Reimbursement for radiologists and pathologists was reduced from 100 percent of reasonable charges to 80 percent. Premiums for SMI were increased, and federal employees were required to pay the HI tax. Outlay reductions and revenue increases from Medicare changes other than hospital reimbursement will total $6.4 billion over 1983-1985.

Few program changes were enacted in Medicaid during 1982. State options to require copayments by recipients were expanded, and states were given the option to place liens on the homes of institutionalized recipients so that benefits could be repaid if a recipient died while institutionalized. Medicaid savings from TEFRA are expected to amount to $0.9 billion over 1983-1985.

Baseline Projections, 1984-1988

Despite the program cuts enacted in 1981 and 1982, Medicare outlays are projected to grow rapidly during the 1984-1988 period, principally because of rising medical care costs. The average rate of increase is projected to be 14.4 percent per year. 7/

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6. Under prospective reimbursement, the rate of payment is set in advance and not based on an individual hospital's actual costs for that year, thereby requiring hospitals to share the risk of increasing costs.

7. The baseline projection assumes that the limits on hospital reimbursement increases (the source of an important part of the reimbursement savings) expire after 1985 and are not renewed. But extension of the targets or substitution of a prospective payment system are distinct possibilities. How stringent any extension or substitute would be, with

Rising baseline outlays for Medicare are a problem both for the size of the budget deficit and for the solvency of the HI trust fund. Under the projections, Medicare will constitute 10.0 percent of the budget by 1988 and the HI trust fund will be exhausted by late 1987. 8/ Unlike the financing problems of the other Social Security trust funds, however, HI deficits are not temporary but grow rapidly. By 1995, annual outlays will exceed payroll tax revenues by about two-thirds. Very large reductions in outlays or increases in revenues to the trust fund, or a combination of both, will be required to maintain solvency.

Medicaid outlays are also expected to increase more rapidly than federal spending as a whole, but at a slower rate than Medicare. From 1983 through 1988, a 10.0 percent annual rate is projected. A slight decline in the AFDC population, further state-level program changes in response to increased flexibility provided in the 1981 Reconciliation Act and TEFRA, and continuing state fiscal pressures are behind the projection of more moderate growth rates.

DEFICIT REDUCTION STRATEGIES

Two broad budget reduction strategies are available in Medicare and Medicaid. One would involve a continuation of the strategy employed thus far--changes in the programs' benefit structure and methods by which providers are reimbursed. The second strategy would involve legislation aimed at the medical care system as a whole. Since general medical care cost increases are the major source of increases in outlays in these programs, policies to slow them may be the only long-term option to reduce federal outlays without substantially reducing benefits.

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its corresponding budget implications, is impossible to predict. A critical factor will be the degree to which hospitals reduce costs in response to the Medicare reimbursement incentives. Cost reductions by hospitals during this period would create opportunities for additional reimbursement reductions in the future.

8. If the reimbursement changes included in TEFRA were extended, so that the 1985 level of savings as a percentage of hospital outlays was maintained, HI's projected insolvency would be postponed by about one year.

PROGRAM CHANGES

Most of the specific program changes discussed below are in Medicare. Given the Congress's 1981 decision to have the states take the initiative in reducing Medicaid costs through increased financial incentives and greater flexibility to make program changes, and the lack of financial resources available to the population served, few options other than additional transfers of responsibility to the states have the potential to reduce federal outlays further without sacrificing Medicaid's goal of improved access to medical care by the poor. The Medicare program changes discussed are grouped as follows:

- Increased beneficiary cost sharing,
- Prospective reimbursement for hospitals, and
- Changes in physician reimbursement.

Increase Beneficiary Cost-Sharing

Changing the structure of Medicare benefits to increase cost-sharing by beneficiaries represents one major option to reduce outlays. Greater cost-sharing could achieve savings in two ways: directly, as a result of increasing the financial responsibility of beneficiaries for medical costs; and indirectly, by discouraging the use of health care services.

The benefit structure of Medicare could be changed in a number of ways to increase cost-sharing by beneficiaries. Some of these ways would involve patient liability for some portion of each medical event. For example, coinsurance (a percentage of the charge) or copayments (a set dollar amount per event) could be assessed against days in the hospital. Finally, payment of premiums for health coverage might also be considered a form of cost-sharing.

Another change that could be implemented in conjunction with greater cost-sharing would be an upper bound on the amount of Medicare out-of-pocket liability that any one beneficiary would be required to pay. To the extent that such changes would provide catastrophic protection to beneficiaries, the latter might be better able to absorb modest increases in yearly medical costs.

A limit on Medicare out-of-pocket expenses set high enough to avoid actually increasing outlays, however, might not provide sufficient relief for moderate-income Medicare enrollees. Although elderly and disabled persons

with the lowest incomes may receive aid through Medicaid, coverage is not universal for all persons with low incomes, and those at slightly higher income levels are largely ineligible. For example, a $3,000 limit on Medicare out-of-pocket expenses would likely be considered too high for someone with $8,000 of income and a high probability of expenses for uncovered services such as drugs. One way to limit the conflict between burdens on low- and moderate-income enrollees and Medicare outlay savings would be to vary the cap on out-of-pocket costs by income.

Expand Hospital Coinsurance. Under current provisions of the Medicare Hospital Insurance program, patients pay a deductible equal to the average cost of one day's hospitalization--$304 in 1983. Medicare beneficiaries pay coinsurance charges (generally 25 percent) only after 60 days of hospitalization for a particular spell of illness. Consequently, only about 0.6 percent of enrollees pay hospital coinsurance in any year.

In addition to the first-day deductible, beneficiaries could be required to pay 10 percent of the deductible amount for each of the next 29 days of a hospital stay in each calendar year--about $35 per day in 1984. For stays beyond 30 days, Medicare would cover all charges, thus improving coverage for participants with extended hospital stays. This option implicitly sets a maximum yearly out-of-pocket individual liability for hospital care of $1,373 in 1984. The Medicaid program would continue to pay the coinsurance costs for those elderly and disabled persons enrolled in both programs. Enactment of this proposal would reduce federal outlays by $16.5 billion over the next five years (see Table IV-2), but state outlays for Medicaid would increase by $840 million.

The option would increase incentives to avoid unnecessary hospital use. But with about 70 percent of Medicare beneficiaries covered by either private supplemental insurance or Medicaid, changes in incentives to conserve on the use of medical services would be limited.

A problem with the option is that out-of-pocket costs would rise substantially for the majority of those elderly and disabled who are hospitalized. Since physicians' fees are already subject to coinsurance under Medicare, the burden of an illness requiring hospitalization could rise to well over $2,000. Moreover, persons ineligible for Medicaid who could not afford the cost-sharing might forgo some needed medical care.

One modification of a hospital coinsurance option would be a cap of $2,000 on total out-of-pocket costs from both HI and SMI in lieu of the 30 day limit on coinsurance for those with incomes below $20,000. Individuals with incomes below this maximum and with high medical expenditures could apply for special status that would entitle them to the limit. Above that

TABLE IV-2. BUDGET SAVINGS FROM PROGRAM CHANGES IN MEDICARE AND MEDICAID (In millions of dollars)

Options	1984	1985	1986	1987	1988	Cumulative Five-Year Savings
Medicare						
Increase Beneficiary Cost-Sharing						
Expand Hospital Coinsurance Days 2-30 a/						
Budget Authority	-190	-520	-800	-1,070	-1,370	-3,950
Outlays	1,980	3,010	3,400	3,820	4,290	16,490
Expand Hospital Coinsurance with Cap on Out-of-Pocket Costs for Some a/						
Budget Authority	-70	-240	-400	-550	-720	-1,980
Outlays	1,190	1,820	2,050	2,320	2,610	9,990
Increase SMI Premiums a/						
Budget Authority	900	1,120	1,700	2,460	3,370	9,550
Outlays	900	1,120	1,700	2,460	3,370	9,550
Increase SMI Premiums for High-Income Families Only						
Budget Authority	240	300	450	650	890	2,530
Outlays	240	300	450	650	890	2,530
Tax the Premiums for Supplemental Coverage b/	2,390	3,610	4,160	4,820	5,470	20,450

(continued)

TABLE IV-2. (Continued)

Options	1984	1985	1986	1987	1988	Cumulative Five-Year Savings
Move to Prospective Hospital Reimbursement						
Replace Reimbursement Limits in TEFRA with Prospective Reimbursement						
Budget Authority	--	--	-80	-300	-580	-960
Outlays	--	--	2,140	4,100	4,610	10,850
Change Physician Reimbursement						
Limit Reasonable Charge Growth						
Budget Authority	40	260	670	1,200	1,830	4,000
Outlays	10	190	590	1,100	1,730	3,620
Adopt Fee Schedules for Surgical Procedures						
Budget Authority	170	700	810	940	1,100	3,720
Outlays	180	680	790	920	1,070	3,640
Medicaid						
Extend Cuts in Matching Grants for Medicaid						
Budget Authority	--	870	660	840	1,040	3,410
Outlays	--	870	660	840	1,040	3,410

a. Savings estimates reflect the concurrent increase in federal Medicaid expenditures.

b. Savings are a combination of outlay reductions and revenue increases. Budget authority estimates are not available.

income limit, beneficiaries would face 10 percent coinsurance on each hospital day after the first. In this case, however, the number of enrollees affected in any year by hospital coinsurance and therefore seeking eligibility for the cap would be relatively small--probably less than 4 percent of all beneficiaries. This option would result in federal savings from coinsurance of $10.0 billion over the 1984-1988 period.

Limiting patients' liability for cost sharing would protect patients from expenses that could wipe out much or all of a family's savings. On the other hand, there are a number of practical difficulties with income-tested benefits including administrative complexities, the arbitrariness of a single cut-off line for granting a limit on liability, and philosophical opposition to subjecting receipt of Medicare to a means test.

A third modification of the hospital coinsurance option could be introduced to give patients incentives to use less expensive hospitals. Instead of reimbursement based on a hospital's own costs, Medicare could reimburse each hospital at a set rate. The rate would compensate providers for, on average, 90 percent of the reasonable hospital costs for a particular area. Patients would be liable for the remainder, with the restriction that no hospital could charge more per day than its own calculated amount of reasonable costs. Moreover, patients in low-cost hospitals would pay less than $35 in coinsurance per day and, in some cases, no coinsurance at all. Savings in federal outlays under this modification would be somewhat higher than if coinsurance was the same at each hospital, since increased competition among hospitals would lower costs and result in somewhat lower reimbursements.

Increase SMI Premiums. Premium receipts have covered a declining percentage of SMI costs each year--falling from 50 percent of all costs in 1972 to 25 percent in 1982. This decline in the enrollees' contribution has resulted because the formula for calculating premium increases was limited to the rate of growth of Social Security benefits, which is tied to the Consumer Price Index rather than to the faster-increasing per capita cost of SMI. Changes passed in TEFRA will stabilize these premiums at 25 percent of the incurred SMI costs for an aged enrollee through June 30, 1985. After that date, the premium calculation is scheduled to be limited again to the rate of growth of Social Security benefits.

If the premium was set so that participants would pay 30 percent of incurred costs per aged enrollee from October 1, 1983, federal savings would total $0.9 billion in 1984 and $9.6 billion over the 1984-1988 period. State outlays for Medicaid, which often pays the premiums for its Medicare-eligible recipients, would increase by about 6.4 percent of that amount, however. Premium costs would rise to an estimated $16.20 per month on October 1, 1983, instead of the scheduled $13.50.

This option would effectively reduce a federal subsidy that has grown to be larger than originally planned. It would not affect the poorest of the elderly and disabled since they are likely to be eligible for Medicaid.

On the other hand, some elderly and disabled persons would still find the increased premiums burdensome, with medical costs consuming an ever-increasing share of their budgets. Some might drop SMI coverage and either do without medical care or turn to sources of free or reduced-cost care, increasing demands on local governments.

To provide relief for moderate-income families, this option could be modified to limit the increase to persons with incomes above a certain level--$20,000 per year, for example. While Medicare savings would fall by 68 percent, the increase would occur only for those elderly and disabled for whom the increased costs are less of a burden. The practical difficulties outlined in the discussion of limiting liability for hospital coinsurance would apply, however, and might be more severe, since all enrollees above the income cutoff--rather than just the 20 percent admitted to a hospital each year--would have to be considered.

Tax the Premiums for Supplemental Coverage. In order to reduce their out-of-pocket payments for deductibles and coinsurance, approximately 58 percent of Medicare enrollees purchase (or receive from former employers) private coverage to supplement Medicare (often called "Medigap"). The plans vary widely, but often pay all the cost-sharing required by Medicare.

By increasing "first-dollar" coverage, Medigap coverage induces enrollees to use services at a higher rate. First-dollar coverage causes patients (and their physicians) to be less sensitive to whether services are needed and to whether the price is too high. This might not be a problem, except that Medigap premiums are heavily subsidized by Medicare. When additional services are used as a result of extra first-dollar coverage, Medicare pays most of their cost (for example, 80 percent of physicians' reasonable charges and the full costs of the second through sixtieth days of hospitalization during a spell of illness). This not only costs Medicare a lot of money--$3.2 billion in 1984--but means that some who purchase Medigap plans do so only because of this subsidy from Medicare.

Imposing a premium tax of 30 percent on Medigap policies that pay any part of the first $1,000 of Medicare cost-sharing would recoup the extra federal outlays arising from supplemental coverage. Federal savings would accrue from both the premium tax receipts and from a reduction in health care use by those who would drop Medigap coverage because of the increase

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in its cost. 9/ If effective January 1, 1984, savings would total $2.4 billion in 1984 and $20.5 billion over the 1984-1988 period.

This option would lead to more equal government aid across all participants by requiring those with Medigap coverage to bear the additional costs they impose on the Medicare system, yet would not affect insurance protection for unusually large health costs. Moreover, most of those elderly and disabled persons with the lowest incomes would be unaffected, since Medicaid provides their supplemental coverage.

On the other hand, the premium tax would increase the cost of Medigap policies and therefore discourage their purchase. Some who would otherwise have purchased supplemental coverage would face difficulties in meeting out-of-pocket costs during a year of unusually high medical expenditures. In addition, since the federal government subsidizes the cost of employment-based health insurance through the tax system (see Appendix A), removing only the Medigap subsidy might be perceived as unfair.

Move to Medicare Prospective Reimbursement of Hospitals by Medicare

In TEFRA, the Congress made some important changes in Medicare reimbursement of hospitals. It expanded existing limits on routine costs to include ancillary costs as well, and established temporary limits on annual increases in hospital reimbursement per case. The conference report indicated that these were interim steps in the direction of a prospective reimbursement system in which payment rates would be established in advance, and hospitals would gain or lose depending on whether costs were below or above these rates. 10/

The Congress could move further toward a prospective reimbursement system for Medicare by paying hospitals a fixed amount per admission, with the amount varying according to the diagnosis-related group (DRG) into which the patient is classified and according to local wage rates. The Secretary of Health and Human Services suggested such an approach in a December 1982 report to the Congress. 11/

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9. Revenues could be dedicated to the trust fund, which finances Medicare hospital coverage.

10. Tax Equity and Fiscal Responsibility Act of 1982, H. Rept. 97-760, 97 Cong., 2 sess. (1982).

11. Richard S. Schweiker, Report to Congress: Hospital Prospective Payment for Medicare (December 1982).

The advantages of such a change from current policies governed by TEFRA would include increased incentives for hospitals to contain costs and an end to using actual costs of individual hospitals during a base period. Opportunities for low-cost hospitals to receive bonuses would be much greater than under current law, which restricts bonuses to 5 percent of target costs, so more hospitals would have incentives to reduce costs. Since hospital reimbursement would not depend on actual hospital costs during a base period, the phenomenon of those hospitals that have long been efficient being inadvertently penalized would be avoided.

On the other hand, the DRG classification system has not been extensively tested and may not yet be accurate enough to serve as the sole basis for reimbursement. Inadequate homogeneity within DRGs could result in large windfall gains and losses to individual hospitals.

Medicare could still move further to prospective reimbursement without possible premature overdependence on DRGs by combining the approach with that of basing rates on actual hospital costs during a base period. The DRG portion of the combined formula could be given greater weight over time as the methodology and the data were refined and as actual costs in a base year became less relevant to the present.

Further movement toward a prospective reimbursement system would be unlikely to lead to significant budget savings until 1986, when the phase-out of the growth rate limits under current law begins. The baseline already reflects substantial reimbursement reductions anticipated under TEFRA, especially in 1985. For a prospective reimbursement system to achieve further budget savings, the prospective rate would have to be set lower than the TEFRA limits, which already are tightening over time. If a prospective reimbursement plan reduced reimbursements relative to the pre-TEFRA baseline by the same 9.1 percent as is now projected under TEFRA for 1985, Medicare savings would amount to $2.1 billion in 1986 and $10.9 billion over the 1986-1988 period.

A critical question in hospital reimbursement policy is whether prospective reimbursement should apply only to Medicare and Medicaid, or whether it should apply to all payers. Many worry about the ability of hospitals to avoid some of the consequences of reduced Medicare reimbursement by raising charges to private payers instead of reducing costs. This issue of program change versus medical care system reform is discussed below.

Change Physician Reimbursement

Currently, the level of reimbursement received by a physician under Part B of Medicare is based on the calculation of "reasonable" charges. This allowable charge may not exceed the lowest of the physician's actual charge, his or her customary charge for that service, or the applicable prevailing charge in the locality. Since 1976, annual increases in the prevailing charge for physicians' services have been limited by an economic index that reflects changes in their operating expenses and earnings levels throughout the economy. Physicians who wish to charge their patients amounts in excess of reasonable charges may do so, however, by refusing to accept "assignment." 12/

Options for cutting physician reimbursements could be directed at reasonable charges for all services or at those for particular services or types of physicians. In all of these options, however, the current ability of physicians to recoup any reduction in Medicare reimbursements by passing on additional charges to beneficiaries is an overriding concern. As long as physicians are permitted to make additional charges to patients, increased savings from reduced reimbursements may be achieved only at the expense of higher costs for beneficiaries.

Two options for changing physician reimbursement are considered in detail below. The first would limit growth in reasonable charges. The second would begin to move Medicare to a system of fee schedules that would allow changes in the relative level of reimbursements across types of services.

Limit Reasonable Charge Growth. Outlays for physician reimbursement could be reduced by restricting the growth rate in allowable charges to the growth in the overall Consumer Price Index (CPI). Though small in 1984, savings would total $3.6 billion over the next five years since the CPI is projected to grow at a lower rate than physicians' fees.

Not all of the costs of this proposal would be borne by the physicians, however. Those who do not accept assignment could raise their extra charges on beneficiaries. Moreover, physicians accepting the allowable charges could respond by increasing the number of services provided, thereby offsetting some of the Medicare savings.

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12. In Medicare, accepting assignment means billing the program for reasonable charges and collecting from the patient only the required deductibles and coinsurance. Physicians unwilling to do this must bill the patient, who in turn submits a claim to Medicare.

An alternative approach to help minimize the amount of additional charges passed on to beneficiaries would be to allow greater growth in allowed charges to physicians accepting assignment. This procedure would benefit those patients whose physicians respond to the incentive for higher reimbursements and decide to accept assignment. By varying the amount of reimbursement according to whether physicians accept assignment, those physicians deciding not to would have to pass considerable costs on to patients if revenues were to be maintained. On the other hand, if many of the physicians currently not accepting assignment continued not to, and made increased additional charges to patients, an important portion of the Medicare outlay reductions would be obtained at the expense of beneficiaries, and the arguments for and against coinsurance would apply.

Adopt Fee Schedules for Surgical Procedures. Medicare could begin to move to a system of fee schedules--that is, a set amount of reimbursement for a particular service--in place of the current system of reasonable charges. Some variation in fees could be allowed, for example, by region or by the location where the service is performed (for example, office, hospital, or clinic). Fees could be based on studies of relative value or other indicators of the time and skill necessary to perform the service, and additional factors could be designed to encourage procedures and locations that are relatively cost-effective.

Since such a broad change in reimbursement would likely require considerable study and negotiation, fee schedules could be incrementally introduced, beginning with surgical procedures. Physicians would be offered a fee for a particular procedure--assuming no complications--that would be known in advance. Since many consider fees for surgery relatively high compared with those for other physician services, the schedule could be set so that allowed charges for surgical procedures were reduced by 10 percent. This would reduce federal outlays by $180 million in 1984 and $3.6 billion over the next five years. Use of such fee schedules could also be coupled with the restriction that physicians accept assignment.

Fee schedules would allow more control over reimbursements by Medicare. No longer would reimbursements necessarily be tied to relationships among types of services reflecting history rather than current relative difficulty. Fee schedules could more readily be adjusted to reflect changes in technology, for example. They could favor, relative to current law, surgery done on an outpatient basis and those procedures deemed relatively cost-effective. As fee schedules were expanded in other areas, the levels could also be set to encourage other changes such as movement of physicians into specialties with traditionally low reimbursement levels--primary care, for example.

Since substitution of fee schedules for the current method of reimbursement for physician services would mark a change from a passive stance on the part of Medicare to more active intervention in the physician services market, many physicians might resist such changes. If coupled with mandatory assignment, some physicians might cease treating Medicare patients. If this happened, beneficiaries would have to balance the more limited choice of physicians with lower out-of-pocket liabilities.

Extend Cuts in Matching Grants for Medicaid

Reductions in matching grants for states enacted in the Reconciliation Act of 1981 expire after fiscal year 1984. Extending them indefinitely would not affect 1984 outlays, but would lower outlays by $3.4 billion from the baseline projection over the following four years.

A notable feature of this method to reduce federal outlays for Medicaid is that state discretion would be maximized. States could decide whether to replace the lost federal grants with their own funds, or, if program cuts were to be made instead, states could choose specific program changes that they believed would depart the least from the goals of the Medicaid program.

Continuation of this shift of financial responsibility to the states may not be desirable, however, especially given the severe effects that the recession has had on the budgets of some states. Some have suggested revising matching rates so as better to reflect interstate variation in fiscal capacity.

MEDICAL CARE SYSTEM CHANGES

Since the major source of rising outlays for Medicare and Medicaid is rising medical care costs, policy changes that would affect the medical care system in other ways than through Medicare/Medicaid may be necessary. These include policies that would encourage competition in the market for medical care, and policies that would increase government regulation of this market. At present, neither competition nor regulation is particularly strong, and spending on medical care is relatively unconstrained.

Toward More Competition. A competitive strategy would involve encouraging increased use of Health Maintenance Organizations (HMOs) and similar organizations for the delivery of medical services, and--for those persons retaining traditional health insurance--encouraging larger deductible amounts and more coinsurance. Those who favor such economic incentives believe they would result in more judicious use of medical services and,

therefore, lower prices. Critics are skeptical about the benefits of this strategy, and about whether it would adequately protect the interests of poor families.

The most important federal measure for increasing competition in medical care would be a change in the tax treatment of employer-paid health insurance. Current policies provide an incentive to shift employee compensation from cash toward health insurance in order to save on taxes. Removal of this tax subsidy, at least for the last dollars contributed by an employer, would increase the use of cost-sharing provisions in insurance policies and spur experimentation with other methods of containing costs such as preferred provider restrictions, where the policyholder is rewarded for restricting himself to providers identified as low-cost. Chapter X on revenues discusses in more detail an option to place a limit on the magnitude of this tax subsidy.

Toward More Regulation. A regulatory strategy would involve increased control by government over resources going to various providers and the allocation of services to different patients. One frequently discussed regulatory tool is prospective reimbursement of hospitals, applied to all payers. It would be more effective in encouraging cost reduction than the Medicare-only option discussed above because hospitals would not be able to shift any of the reimbursement reduction to other payers. After a transitional period, hospitals would reduce the growth in their costs in order to conform to the limited growth in reimbursements. Indeed, the seven states having hospital cost control programs that conform to the definition in the 1981 Reconciliation Act have held increases in per capita inpatient expenses over the 1976-1981 period to 11 percent per year, compared with increases of 14 percent in all other states.

Critics of this type of regulation point to the possibility of errors by the regulators. For example, a hospital's rate could be inadvertently set too low, causing financial problems. In addition, costly distortions could arise through attempts to evade the regulations, such as by increasing admission rates for patients not seriously ill. While each of these problems could affect a Medicare-only system as well, they would be more severe when all payers are included.

An all-payers approach to prospective payment of hospitals could be administered either federally or at the state level. A state-level system would provide a wider range of experience for future development, as well as an ability to adapt the program to local conditions. On the other hand, an important portion of hospital costs is paid by the federal government, so that state incentives alone might be insufficient.

A regulatory approach need not be confined to prospective payment. Limitation of hospital capital spending through health planning has been pursued in some states, though with mixed results. Physician fees could be limited by fee schedules applied to all payers. This option has received only limited consideration in the United States, but is in use in many other Western countries.

CONCLUDING COMMENTS

Rising outlays for Medicare and Medicaid will continue to put pressure on the federal budget and the HI trust fund for some time. Outlays are increasing because of rising medical care costs and the aging of the population, and neither are likely to diminish soon. The long-term solvency of the HI trust fund will require either substantial revenue increases or reductions in outlays far greater than under the program changes being considered today--or both. Program changes can reduce outlays in the short run, but their limited impact on medical care costs means that the critical decisions on medical care and its financing are only being delayed by a few years. Indeed, the projected exhaustion of the HI trust fund may serve to focus more attention on the fundamental issue of rising medical care costs.

CHAPTER V. OTHER ENTITLEMENT PROGRAMS

Most of the programs categorized as "other entitlements" provide direct benefits to persons or families who qualify because their incomes are very low or because they are unemployed, disabled, or old. 1/ These programs are entitlements, in the sense that all individuals who meet the qualifying criteria may receive benefits, and program outlays depend on the number of eligible individuals who apply. Even though large cuts were made in most of these programs in 1981, expenditures in this category grew by about 15 percent between 1980 and 1982, largely because of the increase in the unemployment rate. In fact, growth in outlays for unemployment benefits accounted for almost two-thirds of the total growth in this area.

Two other programs included in this category--General Revenue Sharing (GRS) and Title XX Social Services--provide payments for states and local governments rather than for individuals. They are capped entitlements, whose spending levels are determined in the annual budget process. Outlays for both of these programs have fallen substantially since 1980.

Benefits for Individuals

The programs providing benefits for individuals that are discussed in this chapter fall into three groups:

- Non-means-tested programs, in which persons qualify for benefits for reasons other than income level--for example, because they are unemployed or disabled.

- Means-tested programs, in which low income is a major qualifying criterion, although other characteristics, such as age, disability, or the presence of a dependent child, may also be important in determining eligibility for benefits.

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1. Entitlement programs examined elsewhere in this paper include Social Security, discussed in Chapter II; Medicare and Medicaid, discussed in Chapter IV; and pension and disability benefits for federal workers, discussed in Chapter VIII. Military retirement benefits are discussed in Chapter II, although Veterans' Compensation is discussed in this chapter. Farm price support programs are discussed in Chapter VI.

- o Partially means-tested programs, in which benefits vary with a measure of need, but which extend benefits to some higher-income households.

Non-Means-Tested Benefit Programs. This category includes two programs, Unemployment Insurance (UI) and Trade Adjustment Assistance (TAA), that provide benefits for unemployed workers, and three programs, Veterans' Compensation, Black Lung, and Railroad Retirement, that provide disability and retirement benefits to specific groups of workers, either as a supplement to or as a substitute for Social Security benefits. Three of these programs--UI, Black Lung, and Railroad Retirement--are funded through trust funds, which are financed through earmarked taxes paid by employers and, in some cases, workers.

Means-Tested Benefit Programs. These programs include Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Veterans' Pensions, and Food Stamps. The first three of these provide cash assistance payments to low-income families and individuals who meet the eligibility criteria, which include characteristics such as presence of a dependent child, old age, or veterans' status in addition to low income. The Food Stamp program provides coupons for purchasing food. In the SSI program, most states provide supplementary benefits in addition to the federal SSI benefit. In the AFDC program, federal payments take the form of grants to the states, which are then passed on, in conjunction with matching state funds, to eligible individuals.

Partially Means-Tested Benefit Programs. This category includes the Guaranteed Student Loan (GSL) program, which provides loan subsidies and guarantees for postsecondary students, and the child nutrition programs, which provide subsidized school lunches, school breakfasts, and food supplements for school children. Federal GSL payments go directly to financial institutions providing loans, while child nutrition funds for the most part take the form of federal grants to school districts.

Public Services Grants for States and Localities

The General Revenue Sharing program and the Title XX Social Services program provide grants to states and localities. 2/ GRS provides

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2. As discussed above, the AFDC and child nutrition programs also provide grants to states and localities, but in these two programs federal expenditures are made on behalf of eligible individuals, to whom the funds ultimately go.

general-purpose funds for local jurisdictions, and Title XX provides funds for social services like day care, home help for the handicapped and the elderly, and family planning and counseling. Both of these programs were designed as entitlements for state and local governments, with the shares of funds going to specific governments based on formulas that take into account factors such as the jurisdictions' relative income, population, and tax effort. Unlike most of the entitlement programs for individuals, however, spending under each of these programs is capped, and does not vary automatically with aggregate changes in the factors included in the allocation formulas. The Congress sets the level of the cap in the appropriations process. 3/

BUDGET HISTORY AND PROJECTIONS

In 1982, spending for these entitlement programs came to $87 billion, or about 12 percent of the budget (see Table V-1). The Unemployment Insurance program accounted for more than one-fourth of this total, and the three largest programs--UI, Food Stamps, and Veterans' Compensation--accounted for more than half. Outlays for these programs generally depend, at least to some extent, on the state of the economy; if the unemployment rate falls as projected in coming years, outlays for most will grow little, and in some cases will decline.

Recent History, 1980-1982

Rising rates of unemployment caused total expenditures for these entitlement programs to grow by about 15 percent between 1980 and 1982. Almost two-thirds of this increase was accounted for by higher outlays for unemployment benefits, which grew by about 50 percent. High rates of unemployment probably also indirectly increased outlays for other benefit programs such as Food Stamps and AFDC.

Outlay levels for these programs in 1982 were considerably lower, however, than they would have been if they had been based on 1980 law. Cuts ranging from 10 to 20 percent of projected outlays, and affecting both benefit levels and program eligibility, were enacted in 1981 in all of the means-tested individual-assistance programs except SSI and Veterans' Pensions. Reductions of a similar or greater magnitude were also enacted in Guaranteed Student Loans, child nutrition programs, Unemployment Insurance, Trade Adjustment Assistance, and Title XX Social Services. Appropriations for General Revenue Sharing were not cut in 1981, but were

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3. The cap for Title XX is actually specified in the Social Security Act, and changes in the cap may require an amendment to that act.

TABLE V-1. FEDERAL OUTLAYS FOR "OTHER ENTITLEMENT" PROGRAMS
(In billions of dollars)

Major Program	Actual 1980	Actual 1982	Estimated 1983	Baseline Projection 1984	1985	1986	1987	1988
Benefits for Individuals								
Non-Means-Tested Programs								
Unemployment Insurance	16.4	24.3	33.0	27.8	26.5	26.1	25.9	25.6
Trade Adjustment Assistance	1.7	0.1	0.1	0.1	a/	a/	a/	a/
Veterans' Compensation	7.4	9.3	9.9	10.2	10.6	10.9	11.2	11.3
Black Lung	1.8	2.0	1.8	1.8	1.8	1.8	1.8	1.8
Railroad Retirement b/	4.7	5.3	5.7	5.9	6.0	6.2	6.3	6.4
Means-Tested Programs								
AFDC c/	7.3	8.0	8.1	8.4	8.5	8.8	9.1	9.5
SSI d/	6.4	7.7	8.6	7.4	8.1	8.4	8.6	9.6
Veterans' Pensions	3.6	3.9	3.8	3.7	3.7	3.6	3.5	3.5
Food Stamps e/	9.1	11.0	12.4	12.2	12.5	13.1	13.5	13.8
Partially Means-Tested Programs f/								
Guaranteed Student Loans	1.4	3.0	2.5	2.6	2.9	2.8	2.6	2.5
Child Nutrition	4.7	4.4	4.6	4.9	5.2	5.4	5.7	6.0
Public Service Grants for States and Localities								
General Revenue Sharing	6.9	4.6	4.6	4.7	5.0	5.2	5.5	5.7
Title XX Social Services	2.8	2.6	2.5	2.5	2.6	2.7	2.7	2.7
Total	75.5	87.4	97.6	92.2	93.4	95.0	96.4	98.4

a. Less than $50 million.

b. About 60 percent of outlays for Railroad Retirement provide Social Security benefits for retired railroad workers.

c. AFDC estimates include the Child Support Enforcement program.

d. Fiscal years 1983 and 1988 include 13 months of benefits; fiscal year 1984 includes 11 months.

e. Estimates include nutrition assistance for Puerto Rico.

f. These programs, while partially means-tested, do serve some higher-income households.